



# State of Louisiana

Louisiana Department of Health  
Office of Public Health

## CONFIDENTIAL HEPATITIS B AND HEPATITIS C REPORTING WORKSHEET

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ Tel: ( ) \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ Parish: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex (at birth): <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____ _____/_____/_____	Country of Birth: <input type="checkbox"/> USA <input type="checkbox"/> Other: _____	Date of death: ____/____/____ State of death: _____
Gender (if applicable): <input type="checkbox"/> Male to female transgender <input type="checkbox"/> Female to male transgender <input type="checkbox"/> Other: _____	Hispanic Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Race (check all that apply): <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Other: _____	

### DIAGNOSTIC TESTING

Diagnostic Tests	Collection Date (mm/dd/yyyy)	Ordering Site (if other than reporting facility)
<b>HBV DIAGNOSTIC TESTING</b>		
<input type="checkbox"/> IgM antibody to hepatitis B core antigen [IgM anti-HBc] <input type="checkbox"/> Positive <input type="checkbox"/> Negative	/ /	
<input type="checkbox"/> Hepatitis B surface antigen [HBsAg] <input type="checkbox"/> Positive <input type="checkbox"/> Negative	/ /	
<input type="checkbox"/> Nucleic Acid Testing for hepatitis B [Hep B NAT] <input type="checkbox"/> Positive/Detected <input type="checkbox"/> Negative/Not Detected IU/mL Log IU/mL	/ /	
<input type="checkbox"/> Hepatitis B "e" antigen [HBeAg] <input type="checkbox"/> Positive <input type="checkbox"/> Negative	/ /	
<input type="checkbox"/> Other (specify): _____	/ /	

<b>HCV DIAGNOSTIC TESTING</b>		
<input type="checkbox"/> Antibody to HCV [anti-HCV] <input type="checkbox"/> Positive <input type="checkbox"/> Negative anti-HCV signal to cut-off _____	/ /	
<input type="checkbox"/> HCV RNA/PCR Qualitative <input type="checkbox"/> Positive/Detected <input type="checkbox"/> Negative/Not Detected	/ /	
<input type="checkbox"/> HCV RNA/PCR Quantitative IU/mL Log IU/mL	/ /	
<input type="checkbox"/> HCV Genotype _____	/ /	
<input type="checkbox"/> Other (specify): _____	/ /	

### CLINICAL INFORMATION

<input type="checkbox"/> Is patient experiencing symptoms consistent with hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, onset date ____/____/____	Has patient received medication for hepatitis being reported? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of earliest use: ____/____/____ Please list known hepatitis medications and duration: _____
<input type="checkbox"/> At diagnosis, was the patient Jaundiced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Hospitalized for hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

Is patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, estimated date of delivery: ____/____/____	Please mail or fax to: ATTN: Hepatitis Surveillance STD/HIV/Hepatitis Program Louisiana Office of Public Health PO Box 60630 New Orleans, LA 70160 Ph: (504) 568-7474 Fax: (504) 568-8384
Was patient vaccinated for Hepatitis B within last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, date of most recent vaccination: ____/____/____	

### REPORTING INFORMATION

Reporting Facility: _____ Date: _____	Please mail or fax to: ATTN: Hepatitis Surveillance STD/HIV/Hepatitis Program Louisiana Office of Public Health PO Box 60630 New Orleans, LA 70160 Ph: (504) 568-7474 Fax: (504) 568-8384
Address: _____ City: _____ State: _____ Zip: _____	
Reporting Physician: _____ Phone: ( ) _____ - _____	
Person Completing Form: _____ Phone: ( ) _____ - _____	

## To Our Providers:

This worksheet was developed to assist with timely reporting of Hepatitis B and C cases by the diagnosing and/or managing physician, by collecting the most critical information requested by the Centers for Disease Control and Prevention (CDC). In some cases, staff of the STD/HIV/Hepatitis Program (SHHP), under the Department of Health Office of Public Health, may need to contact the facility for additional information not included on this worksheet. If a provider prefers to complete the CDC Viral Hepatitis Case Report Form him- or herself, copies may be obtained from the SHHP contact listed at the bottom of the form. Case reports may also be made by phone to the SHHP contact, or SHHP staff can complete the required forms on site via a chart review. *Please include as much information as is available; partial or approximate dates are acceptable for historical information.*

When present the signs and symptoms of acute hepatitis infection include fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, dark urine, clay-colored bowel movements, joint pain, and jaundice.

A hepatitis B blood panel should be used to screen for HBV and includes hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (Anti-HBs) and hepatitis B core antibody (anti-HBc). All positive results and additional testing to monitor persons with hepatitis B infection should be reported.

HCV antibody testing with reflex to HCV RNA polymerase chain reaction testing is recommended for initial hepatitis C screening. Among persons at risk for reinfection after previous spontaneous or treatment-related viral clearance, HCV-RNA testing is recommended because a positive HCV-antibody is expected. All results and additional testing to monitor persons with hepatitis C infection should be reported.

Guidance on Hepatitis B and Hepatitis C can be found through the American Association of Liver Diseases (aasld.org) and CDC (cdc.gov/hepatitis).

**Reporting Requirements:** Louisiana's Public Health Sanitary Code (Title 51, Part II, Chapter 1) requires that any physician practicing medicine in the State of Louisiana who attends or examines a person with Hepatitis B (acute, carriage in pregnancy or perinatal infection) or Hepatitis C (acute or perinatal infection) must report the case by the end of the next business day after the existence of a case, suspected case, or a positive laboratory result is known (Class B). Chronic Hepatitis C infection is reportable within 5 business days (Class C). Positive laboratory results for Hepatitis B and all laboratory results (both positive and negative) for Hepatitis C are reportable. Other health care providers, laboratories, and other entities have similar reporting requirements.

**HIPAA Guidelines Related to Disclosures for Public Health Activities:** The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. See 45 CFR 164.512(b)(1)(i).